Eur J Vasc Endovasc Surg 9, 361–363 (1995)

Correspondence

Aneurysm Repair

Sir,

Johansson and Swedenborg (*Eur J Vasc Surg* 8: 489–493) draw attention to the failure of current levels of elective AAA surgery in Stockholm to produce any detectable impact on the mortality from ruptured AAA. Their experience is identical to that in Oxford where the number of patients presenting with ruptured AAA shows no sign of decreasing. The explanation is not hard to find.

The rupture rate for all AAA's more than 5.0 cm diameter is unknown but the probability is that the figure lies between 5–10%. If the higher figure is correct the 125 ruptured AAAs that occurred in Stockholm in 1989 indicate a pool of around 1200 individuals with AAAs who could have been considered for elective surgery. If the true rupture rate is 5% per annum the pool of potential patients in 1989 was around 2500. Given that the pool is not static and will receive an inflow of new subjects with AAA at least equal to the outflow from the pool by death, the probability is that between 1500 and 4000 patients would have had to receive elective AAA surgery over the previous 5 years to substantially reduce deaths from ruptured AAA in 1989. The 340 elective resections for AAA performed in 1984–89 may account for fewer than 10% of potential patients in the pool at some time during the 5 years.

Like the horse "Boxer" in George Orwell's novel Animal Farm, the solution would seem to be for us all to work harder.

J. Collin
Oxford, U.K.

Author's Reply

It is reassuring that Mr Collin arrives at the same conclusions as we did in our article **"Little impact of elective surgery on the incidence and mortality of ruptured aortic aneurysms"**. We did not think that it was completely evident that an increase in elective surgery should have no influence on the mortality from rupture of AAA and therefore undertook the study. The most probable reason for the lack of effect of an increased rate of elective surgery is probably that too little elective surgery is done as clearly stated in our discussion, a statement which Mr Collin agrees with.

J. Swedenborg
Stockholm, Sweden

DVT Diagnosis

Sir,

We read with interest the paper by Wester *et al.*,[1] regarding the use of non-invasive modalities to confirm or exclude the presence of thrombosis. We have a reservation regarding the use of compression ultrasonography (CUS). The thrombus within the ileofemoral veins is friable and often loosely adherent to the vein wall, detachment of the thrombus may lead to massive fatal pulmonary embolus (PE). Standard teaching suggests that eliciting Homan's sign may lead to detachment of thrombus with subsequent PE.[2,3] It follows that compression of the deep veins with the ultrasound probe, with the intention of opposing the vein walls until *"no residual lumen"* remains may fracture or detach thrombus precipitating pulmonary embolism although this has not been reported clinically. If grey scale or colour duplex scanning is available its use would be preferable as there is a reduced theoretical risk of precipitating a PE.

L. Fligelstone and R. Salaman
Cardiff, Wales

1078–5884/95/030361 + 04 $08·00/0